



INSTRUCTIONS FOR COMPLETING THE NHSC MULTI-YEAR RECRUITMENT AND RETENTION ASSISTANCE APPLICATION

1. **Practice Site:** Name, address, telephone number, and e-mail address of the site requesting recruitment assistance for a full-time NHSC clinician(s), the U.S. Congressional District number(s) and type of practice at site. (A separate application is required for each site location.)
2. **Parent Agency:** Name and address of parent agency, if different from practice site.
3. **Recruitment Contact:** Name, telephone, fax, and e-mail address of individual responsible for recruitment.
4. **Mailing Address:** Name, mailing address, and e-mail address of the Executive Director.
5. **Staffing Levels:** Enter the total number of budgeted full-time equivalent clinicians and those currently on staff; the number of requested clinicians by discipline and specialty for which NHSC assistance is requested and active recruitment will be undertaken; the projected hire date.

NOTE: It is extremely important that the projected hire date for all clinicians be as accurate as possible. Give date with month and year.

- 5a. List the name(s) of the specific individual for whom NHSC loan repayment is requested, if applicable.
6. **Signature of Site Official and date.**
7. **Signature of State Health Official and date.**
8. **Agreement for All Participating NHSC Sites:** Enter the name and address of site. Name, date, and signatures of Approving Site Official.
9. **Mail or fax this application to HRSA/Site Identification and Application Branch, 5600 Fishers Lane, Room 8A-55, Rockville, Maryland, 20857. Fax # 301-594-2721. If you have any questions call 301-594-4165.**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. The OMB control number for this project is 0915-0230. Public reporting burden for the applicant for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland, 20857.



OMB Number: 0915-0230

Expiration Date: 04/02/2005

NHSC USE ONLY

HPSA TYPE: _____

HPSA ID #: _____

BCRR #: _____

**NHSC MULTI-YEAR RECRUITMENT
AND RETENTION ASSISTANCE APPLICATION**

1. Practice Site: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____
Urban _____ Rural _____
Telephone Number: _____ Fax: _____
E-Mail Address: _____
U.S. Congressional District Number: _____
Type of Practice: _____ HRSA/BPHC Funded _____ Private Non-Profit
_____ For Profit _____ Other Public
_____ Indian Health Services _____ Bureau of Prisons _____ Division of Immigration Health Services
2. Parent Agency: _____
Street Address: _____
City/State, Zip Code: _____
3. Recruitment Contact: _____
Telephone Number: _____ Fax: _____
E-Mail Address: _____
4. Mailing Address (if different from site address):
Executive Director: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
E-Mail Address: _____

5. Staffing Levels

PHYSICIANS	STAFFING LEVEL		NUMBER OF NHSC PROVIDERS REQUESTED	PROJECTED HIRE DATE MONTH AND YEAR
	FULL	CURRENT		
Family Practice OB Required? Yes / No				
Internal Medicine				
Pediatricians				
Obstetrician/Gynecologists				
Psychiatrists				
NURSE PRACTITIONERS				
Family Nurse Practitioners				
Adult Nurse Practitioners				
Geriatric Nurse Practitioners				
Pediatric Nurse Practitioners				
Women's Health Nurse Practitioners				
Psychiatric Nurse Practitioners				
OTHER DISCIPLINES				
Physician Assistants				
Nurse Midwives				
Dentists				
Dental Hygienists				
Clinical Psychologists				
Clinical Social Workers				
Psychiatric Nurse Specialists				
Licensed Professional Counselors				
Marriage & Family Therapists				

5a. Proposed Loan Repayors: Name, Discipline/Specialty

6. Signature of Site Official: _____ Date: _____

Title: _____

7. Signature of State Health Official: _____ Date: _____

Title: _____



8. AGREEMENT FOR ALL PARTICIPATING NHSC SITES

We, _____
Site Name and Address
_____ agree to:

- A. We use a sliding fee schedule and/or other documentable method to reduce fees that assures no financial barriers to care exist, which includes accepting assignment of "Medicare" and enter into an agreement with the State agency that administers "Medicaid."
- B. We will or do prominently advertise a statement expressing that no one will be denied access to services due to inability to pay.
- C. We have a policy of non-discrimination based upon race, color, sex, national origin, disability, or religion.
- D. We will or do ensure that at least 80 percent of the patients to be seen by the NHSC clinician will reside in the HPSA where the practice is located.
- E. We will or do provide culturally appropriate ambulatory primary health, dental health, and/or mental health care services.
- F. We use a credentialing process which, at a minimum, includes reference review, licensure verification, and a query of the National Practitioner Data Bank (NPDB) of those clinicians for whom the NPDB maintains data.
- G. We function as part of a system of care which either offers or assures access to ancillary, inpatient, and specialty referrals.
- H. We adhere to sound fiscal management policies and adopt clinician recruitment and retention policies to help the patient population, the site, and the community obtain maximum benefits.
- I. We will or currently pay NHSC clinicians a salary and benefit package, including professional liability coverage (which must include tail coverage), at least equal to those that would be offered to a comparably trained and experienced civil service employee of the United States Department of Health and Human Services, if the NHSC clinician signs a Private Practice Assignment (PPA) Agreement.
- J. We will or currently require NHSC clinicians to maintain a full-time clinical practice, working a minimum of 40 hours per week for at least 45 weeks per year.
- K. We support clinicians with funding and arrangements, including clinical coverage, for their time away from the site to attend NHSC sponsored meetings and other continuing education programs.
- L. We will communicate to the NHSC any change in site or clinician status that might adversely affect the site or a clinician continuing an established relationship with the NHSC.
- M. We will maintain and make available for review by NHSC representatives all personnel and practice records (including Uniformed Data System) associated with an NHSC clinician including documentation which contains such information that the Department may need to determine if the individual has complied.
- N. We will adhere to cost sharing requirements as listed in section 334 of the Public Health Service Act.

Signatures below are assurance that this application contains true and correct information and that the site agrees to comply with all of the above requirements of this agreement.

Name of Site Official: _____

Signature of Approving Site Official: _____

Title: _____ Date: _____